

CareAffiliate® Guide

Using CareAffiliate at www.tricare-west.com

Use this guide to assist you in using CareAffiliate – Health Net Federal Services, LLC’s (HNFS’) online referral and authorization submission tool for the TRICARE West Region. Use CareAffiliate for both outpatient and inpatient requests.

All TRICARE West Region referral and authorization requests must be submitted online.

Remember ... Not all specialty services require a referral or authorization. Use our online [Prior Authorization, Referral and Benefit](#) (PARB) tool, our [Ancillary Services Approval Requirements](#) tool, and our [Benefits A–Z](#) pages to quickly and easily determine whether an HNFS approval is needed. If the service doesn’t require HNFS approval, then there’s nothing to submit. You can print your results from PARB for your patient files.

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Section 1: Getting Started

To use this tool, you'll first need to log in to www.tricare-west.com, as requests submitted are tied to the provider Tax Identification Numbers (TINs) associated with your www.tricare-west.com account.

Helpful tips

- Use Google Chrome or Microsoft Edge for best results.
- Clear all cookies.

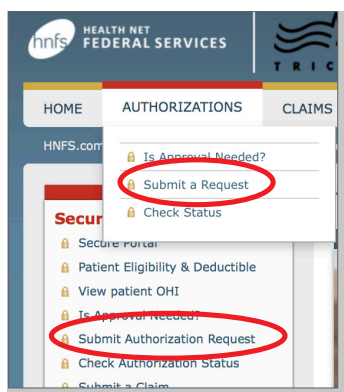
1. **Log in to the secure provider portal.** If you do not yet have a username/password, click the “Register” link to learn more.



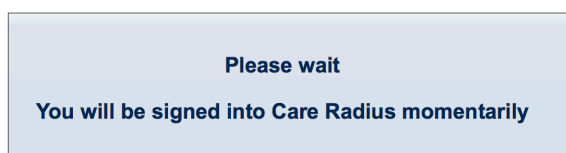
Note: Passwords expire after 365 days. To set a new password, just follow the change password prompts.

2. **Click on Submit Authorization Request.**

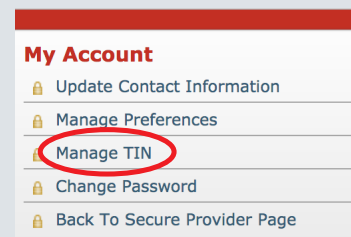
Locate this link in the **Secure Tools** box in the left navigation pane and in the **Authorizations** tab drop-down menu. Both links take you to the same place.



3. **You will be re-directed to CareRadius.** CareRadius is a sub-set of CareAffiliate.



Why Tax Identification Numbers are Important



Your web registration account is linked to your provider Tax Identification Number or TIN. Without this link, you will be unable to select a requesting provider within CareAffiliate and therefore, be unable to submit the request.

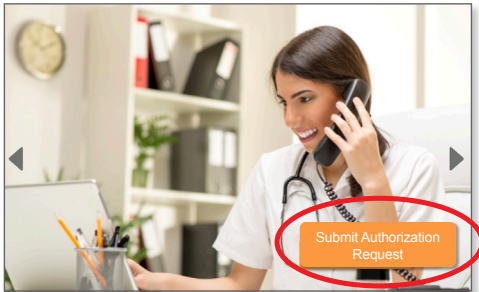
To determine which TIN your registration is linked to, go to the top or left navigation and click on **My Account** > **Manage TIN** to display the provider TIN or TINs that are linked to your account. From here, you can also add additional TINs to your account. Just like when you initially registered on the website, to add TINs you'll need two claim or authorization numbers.

Section 2: Submit a Request

Here are some tips to keep in mind:

- There are multiple ways to search: magnifying glass icon, drop-down menus, “type-ahead” fields, and “wild card” searches using asterisks.
- Certain fields, such as member and requesting provider, have links displayed to the left that allow you to view more details.
- Fields outlined in orange are required fields. If a field is grayed out, it means it is locked and cannot be edited.

1. Click on **Submit Authorization Request**.



2. Search for a member. Click on the magnifying glass symbol to **start your search**.

A screenshot of a web form titled 'Authorizations'. Under the 'General Information' section, there are three input fields: 'Member ID' (with a placeholder 'Click Look Up icon -->'), 'Name', and 'Request Type'. Each of these fields has a magnifying glass icon to its right. The magnifying glass icon for the 'Member ID' field is circled in red.

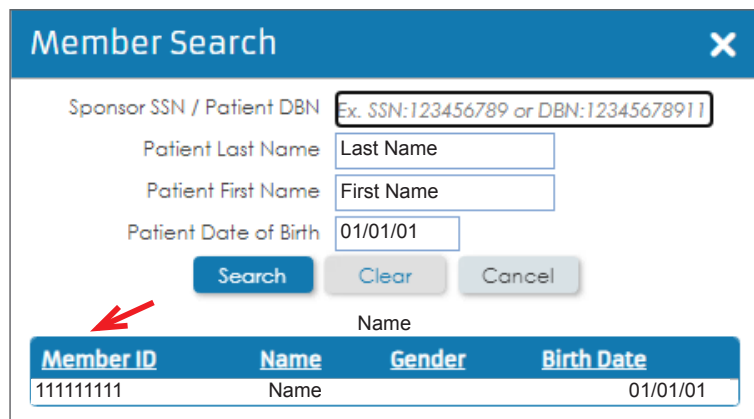
3. Enter in the patient's information. All fields are required.

Tip: Be sure to enter the patient's date of birth in the 2-digit month, 2-digit day and 4-digit year format.

A screenshot of a 'Member Search' dialog box. It has a blue header with the title 'Member Search' and a close button (X). The form contains the following fields: 'Sponsor SSN / Patient DBN' with a placeholder 'Ex. SSN:123456789 or DBN:12345678911', 'Patient Last Name', 'Patient First Name', and 'Patient Date of Birth'. At the bottom, there are three buttons: 'Search' (blue), 'Clear' (gray), and 'Cancel' (gray).

Section 2: Submit a Request *(continued)*

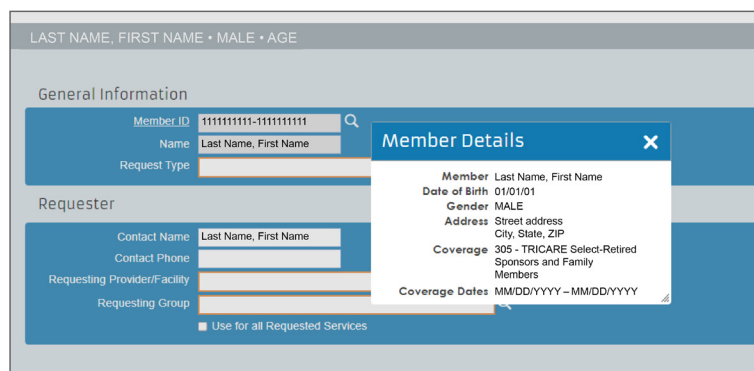
4. Select the beneficiary.



The Member Search form has a blue header with the title "Member Search" and a close button (X). Below the header, there are input fields for "Sponsor SSN / Patient DBN" (with an example: "Ex. SSN:123456789 or DBN:12345678911"), "Patient Last Name", "Patient First Name", and "Patient Date of Birth". Below these fields are three buttons: "Search" (highlighted with a red arrow), "Clear", and "Cancel". At the bottom, there is a table with the following data:

Member ID	Name	Gender	Birth Date
111111111	Name		01/01/01

5. Verify the beneficiary information by clicking on "Member ID." If changes are required, refer to step 21.

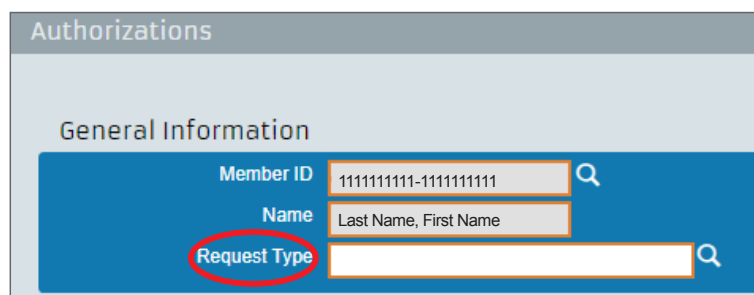


The Member Details form is a modal window with a blue header and a close button (X). It contains a "General Information" section with fields for "Member ID" (111111111-111111111), "Name" (Last Name, First Name), and "Request Type". Below this is a "Requester" section with fields for "Contact Name", "Contact Phone", "Requesting Provider/Facility", and "Requesting Group". A checkbox labeled "Use for all Requested Services" is at the bottom. A "Member Details" sidebar on the right displays the following information:

- Member: Last Name, First Name
- Date of Birth: 01/01/01
- Gender: MALE
- Address: Street address, City, State, ZIP
- Coverage: 305 - TRICARE Select-Retired Sponsors and Family Members
- Coverage Dates: MM/DD/YYYY - MM/DD/YYYY

6. Enter the request type. Request types are templates created by HNFS for referral and authorization submissions. Each request type has specified codes/code ranges that will pre-populate in the request.

Tip: Do not use "Evaluate and Treat" request types for therapies (for example, physical therapy) or mental health services.



The Authorizations form has a blue header with the title "Authorizations". Below the header is a "General Information" section with fields for "Member ID" (111111111-111111111), "Name" (Last Name, First Name), and "Request Type" (circled in red). Each field has a search icon (magnifying glass) to its right.

Section 2: Submit a Request *(continued)*

The easiest way to find the appropriate request type is by using the **Request Types** charts.

Request Types

The associated codes/code ranges, number of visits, and duration of the authorization will populate based on the request type selected.

To view the different request type tables, click on the appropriate category:

Outpatient specialty referrals
(provider to provider)
Outpatient authorizations
- physical health
- behavioral health
Durable medical equipment
Inpatient authorizations

Description	Included CPT® Code(s)	Request Type	Approval Duration
Evaluate and Treat Specialty Referral	99202–99205, 99211–99215, 99242–99245	P1	180 days for ADSMs 365 days for non-ADSMs
Evaluate Only Specialty Referral	99202–99205, 99211–99215, 99242–99245	P3	180 days
Oncology – Evaluate and Treat Spec Ref	99202–99205, 99211–99215, 99242–99245	P6	365 days
Pre/Post Transplant	99211–99215, 99242–99245	P58	360 days for codes 99211–99215 90 days for codes 99242–99245

(Sample)

Also see Section 3: Request Types/Adding Codes.

Below are two ways to search for a request type.

- a. Type the request type description into the **Request Type** box and select the appropriate request type. (For example, start typing the word “evaluate” and a drop-down menu will display.)

LAST NAME, FIRST NAME • MALE • AGE

General Information

Member ID: 111111111-111111111

Name: Last Name, First Name

Request Type: Evaluate

Requester: Evaluate and Treat Specialty Referral, Evaluate Only Specialty Referral, Oncology - Evaluate and Treat Spec Ref

Contact Name: Ref

Contact Phone:

- b. When the Request Type Description window pops up, all request types available will appear automatically. However, you can still search for the needed request type. If you aren't sure what request type you need based on the request type charts, click on the magnifying glass to display the **Request Type Selection** search box.

Request Type Selection

Request Type Description: [Search Box]

Procedure: [Search Box]

Specialty: [Search Box]

Show Inpatient Only ☐

Show Behavioral Health / Substance Abuse only ☐

Search Clear Cancel

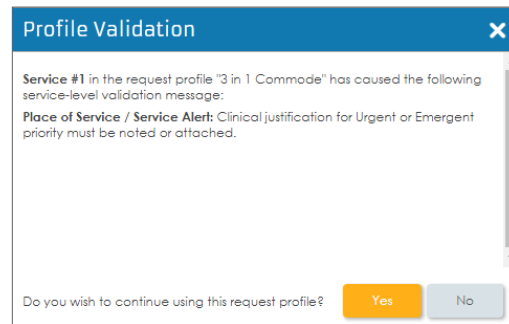
Click on the magnifying glass to the right of the **Procedure** box. Another box will appear; enter in a CPT®, NDC, or HCPCS code in the **Code** box and click the **Search** button to view a description and/or select the procedure. If the code you entered is included in one of our request types, those request types will be displayed and you can choose the appropriate option. If a request type does not display, you must then choose an appropriate generic request type. (See Section 3: Generic Request Types/Adding Codes)

Section 2: Submit a Request *(continued)*

7. Review the profile validation message (if applicable).

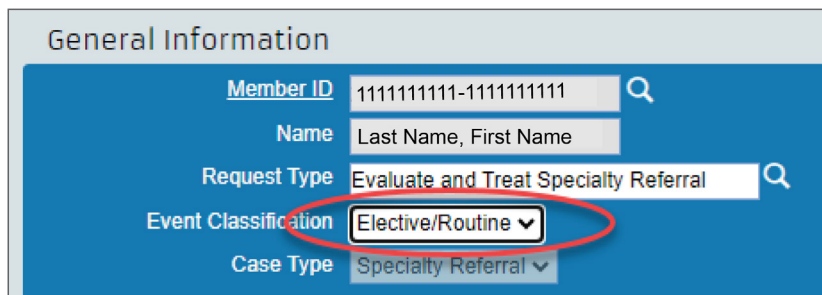
Pay close attention to these types of messages!

They may require you to do additional actions prior to submitting your requests.



A dialog box titled "Profile Validation" with a close button (X) in the top right corner. The text inside reads: "Service #1 in the request profile '3 in 1 Commode' has caused the following service-level validation message: Place of Service / Service Alert: Clinical justification for Urgent or Emergent priority must be noted or attached." At the bottom, there is a question "Do you wish to continue using this request profile?" followed by two buttons: "Yes" (orange) and "No" (gray).

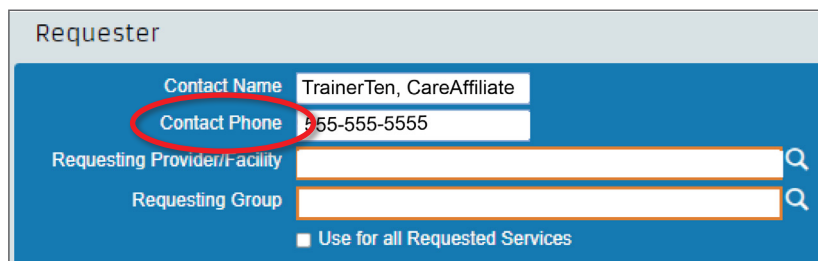
8. Select the event classification.



A form titled "General Information" with a blue header. It contains several fields: "Member ID" with the value "111111111-111111111" and a magnifying glass icon; "Name" with the placeholder "Last Name, First Name"; "Request Type" with the value "Evaluate and Treat Specialty Referral" and a magnifying glass icon; "Event Classification" with a dropdown menu showing "Elective/Routine" (circled in red); and "Case Type" with a dropdown menu showing "Specialty Referral".

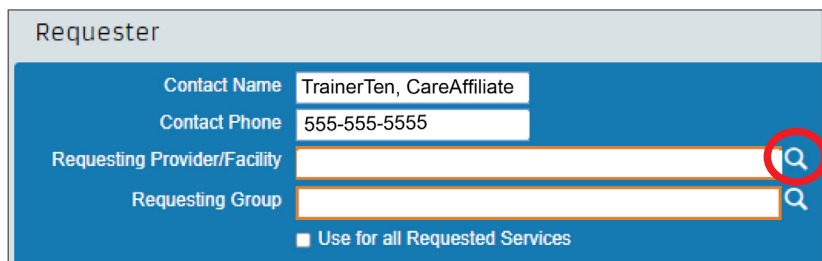
Tip: Use **Elective/Routine** when care is needed within the four-week TRICARE specialty care access standards. Nearly all referral requests are routine unless the patient needs care in less than 72 hours; use **Urgent** when care is needed within 24–72 hours; and use **Emergency** when care is needed within 24 hours or less.

9. Input your phone number in the “Contact Phone” field. The contact information included here is the contact information of the person who is submitting the request.



A form titled "Requester" with a blue header. It contains several fields: "Contact Name" with the value "TrainerTen, CareAffiliate"; "Contact Phone" with the value "555-555-5555" (circled in red); "Requesting Provider/Facility" with a magnifying glass icon; "Requesting Group" with a magnifying glass icon; and a checkbox labeled "Use for all Requested Services".

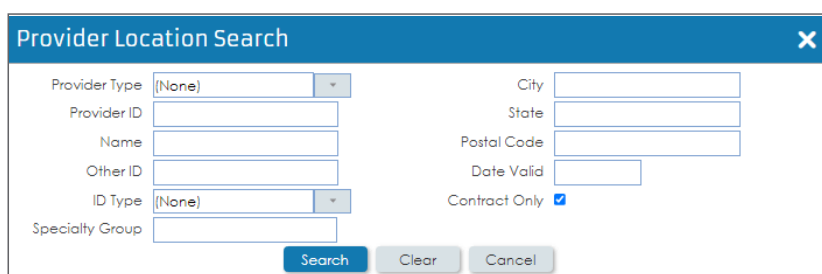
10. Select a requesting provider/facility or group. Start by clicking on the magnifying glass.



A form titled "Requester" with a blue header. It contains several fields: "Contact Name" with the value "TrainerTen, CareAffiliate"; "Contact Phone" with the value "555-555-5555"; "Requesting Provider/Facility" with a magnifying glass icon (circled in red); "Requesting Group" with a magnifying glass icon; and a checkbox labeled "Use for all Requested Services".

Tip: “Provider/Facility” = individual provider, “Group” = medical group (includes DME, home health and laboratory providers). You only need to enter provider/facility OR group for outpatient specialty referrals.

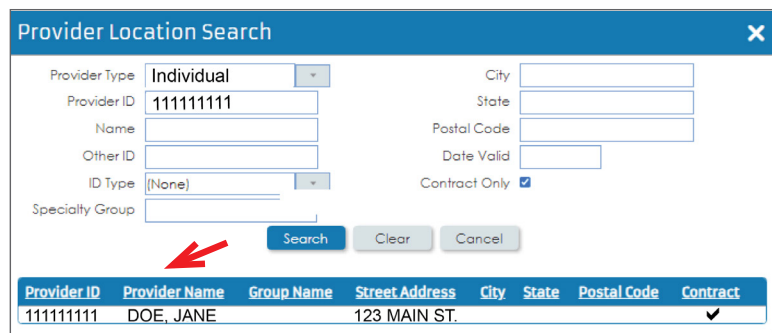
11. Search for the requesting provider by TIN, name, or other filters to narrow your search. All the TINs associated with your web account will display. (See “Why Tax Identification Numbers are Important” on page 2.)



A form titled "Provider Location Search" with a blue header and a close button (X) in the top right corner. It contains several fields: "Provider Type" with a dropdown menu showing "(None)"; "Provider ID" with a text input field; "Name" with a text input field; "Other ID" with a text input field; "ID Type" with a dropdown menu showing "(None)"; "Specialty Group" with a text input field; "City" with a text input field; "State" with a text input field; "Postal Code" with a text input field; "Date Valid" with a text input field; and a checkbox labeled "Contract Only" which is checked. At the bottom, there are three buttons: "Search" (blue), "Clear" (gray), and "Cancel" (gray).

Section 2: Submit a Request *(continued)*

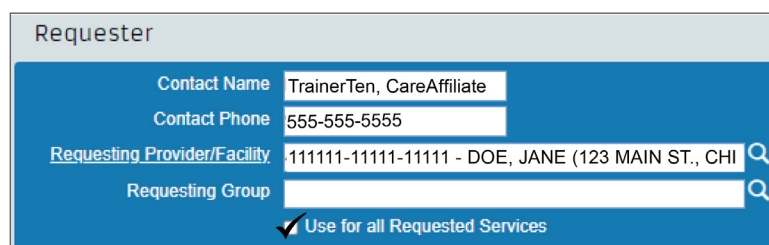
- 12. Select a requesting provider location.** Choose from the drop-down menu or use other filters to narrow your search.



The 'Provider Location Search' dialog box contains several input fields: 'Provider Type' (set to 'Individual'), 'Provider ID' (111111111), 'City', 'State', 'Postal Code', 'Date Valid', 'ID Type' (set to 'None'), 'Specialty Group', and a 'Contract Only' checkbox (checked). Below these fields are 'Search', 'Clear', and 'Cancel' buttons. A red arrow points to the 'Search' button. At the bottom, a table displays search results.

Provider ID	Provider Name	Group Name	Street Address	City	State	Postal Code	Contract
111111111	DOE, JANE		123 MAIN ST.				✓

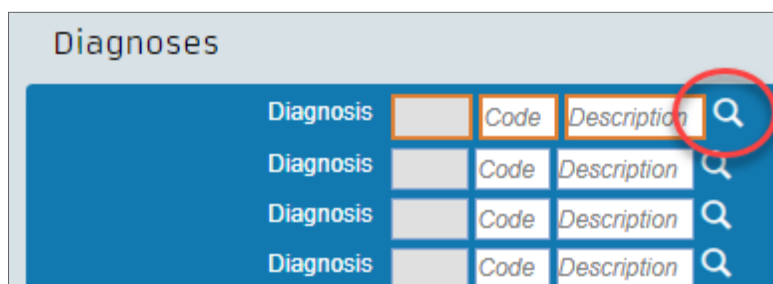
Once you select a record, the provider information will populate.



The 'Requester' form includes fields for 'Contact Name' (TrainerTen, CareAffiliate), 'Contact Phone' (555-555-5555), 'Requesting Provider/Facility' (111111-11111-11111 - DOE, JANE (123 MAIN ST., CHI), and 'Requesting Group'. A checkbox labeled 'Use for all Requested Services' is checked.

Tip: If the requesting provider is also going to be the servicing provider, check the "Use for all Requested Services" box.

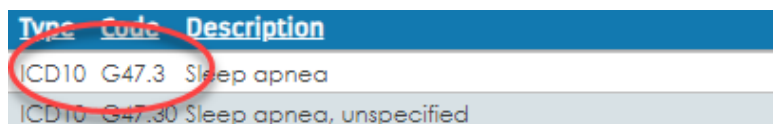
- 13. Enter the diagnosis.** Enter in your ICD-10 code or click on the magnifying glass if you don't have a code.



The 'Diagnoses' section features a table with four rows. Each row has columns for 'Diagnosis', 'Code', and 'Description', followed by a magnifying glass icon. The first row is highlighted.

Diagnosis	Code	Description	
			🔍
			🔍
			🔍
			🔍

Always select ICD-10 codes, even if ICD-9 codes show in the drop-down menu or search results.



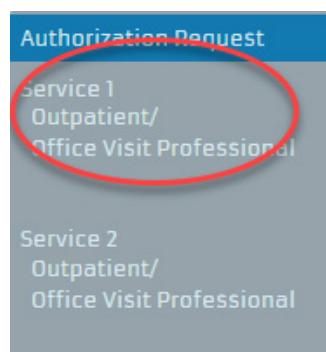
A table showing search results for diagnosis codes. The first two rows are highlighted.

Type	Code	Description
ICD10	G47.3	Sleep apnea
ICD10	G47.30	Sleep apnea, unspecified

Tip: CareAffiliate lets you add up to four diagnosis codes, with the first diagnosis considered to be primary. If there are additional codes, enter them in the Notes feature in the left navigation blue section.

- 14. Select a service line from the left navigation blue section.**

The request type selected determines the number and type of service lines shown.



The 'Authorization Request' sidebar shows two service lines. The first service line is circled in red.

Service 1
Outpatient/
Office Visit Professional

Service 2
Outpatient/
Office Visit Professional

Section 2: Submit a Request *(continued)*

15. Search for the servicing provider (if different from the requesting provider). Start by clicking on the magnifying glass.

Service #1 - Office Visit Professional

Status Reason	Submitted For Review
Place of Service	Outpatient
Service	Office Visit Professional
Service From	06/14/2023
Provider	
Group	
Facility	
Provider Specialty	

Tip: If you don't have a servicing provider in mind, HNFS can help you locate one by typing in a specialty description in the provider specialty section.

16. Use the TIN, name or other filters to narrow your search.

Provider Location Search

Provider Type	(None)	City	
Provider ID		State	
Name		Postal Code	
Other ID		Date Valid	
ID Type	(None)	Contract Only	☒
Specialty Group			

17. Enter the specialty.

Service #1 - Office Visit Professional

Status Reason	Submitted For Review
Place of Service	Outpatient
Service	Office Visit Professional
Service From	06/14/2023
Provider	
Group	
Facility	
Provider Specialty	
Provider Role	Servicing

Tip: You **MUST** enter the servicing provider's specialty for each service line.

18. For inpatient only.

Home Authorizations Program Enrollment Care Plan Help

Tip: If a provider is submitting an inpatient request with a retroactive date of service, the system will only accept it if it is entered into the "Actual Date Admitted" field. Using the "Service From" field will result in an error message.

CareAffiliate®

Specialty is required for ServiceLine #: 0000021089-001 [HNFS_SVC_013] Service From date cannot be before today. Please update Service From date.

Authorizations

Section 2: Submit a Request (continued)

19. Repeat for additional service lines.

The screenshot shows the CareAffiliate interface with a navigation bar (Home, Authorizations, Program Enrollment, Care Plan, Help) and a 'Submit' button. Below is a table with columns for 'Total Qty' and 'Primary'. A row is visible with '1' and a checkmark. Above the table are buttons for 'Copy Service Line' and 'Delete Service Line'. Below the table are buttons for 'Add Procedure' and 'Delete Selected', both of which are crossed out with red X's.

Tip: CareAffiliate has several copy shortcut functions like **copy service** and **copy provider** when entering requests with multiple service lines. To avoid delays in processing requests, do not add a generic request type to a non-generic request type.

Example: Office visits should be sent as a separate request from a surgical procedure. Non-generic request types are pre-populated templates specifically designed by HNFS.

20. Review the procedure codes/code ranges covered under each service line.

Keep in mind:

- The **Edit**, **Add Procedure** and **Delete Selected** functions cannot be used with most request types. (See Section 3: Generic Request Types/Adding Codes).
- The **servicing** provider will determine if additional services are needed and submit any required authorization request to HNFS (**Tip:** Most diagnostic services and office procedures do not require a separate authorization).

Procedure Information					
		Type	Procedure Low	Procedure High	Total Qty
☐	Edit	CPT	99202 - Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter.	99205 - Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.	1

21. Add notes and/or attachments, if applicable.

The assessment function can be used to recommend provider demographic updates or update the beneficiary's address. (See Section 4: Adding Notes, Attachments and Assessments)

Note: Requesting demographic updates using the assessment feature will only update the information for the request being submitted. Providers should use the Update Demographics tool to make permanent changes. Beneficiaries must update their record in the Defense Enrollment Eligibility Reporting System to make permanent changes.

A form with three sections: 'Notes' with a count of '(0)', 'Assessment' with a count of '(0)', and 'Attachments' with a count of '(0)'.

22. Submit your request.

A button labeled 'Submit'.

Section 3: Generic Request Types/Adding Codes

Q: When should I select a generic request type?

A: You should only select a generic request type if the codes you are searching for do not fall within one of our request type templates.

Q: How do I know which request types are generic?

A: Generic request types generally have the word “generic” in the description. To help, we’ve notated all generic request types in the tables at the end of this guide with an asterisk.

General Information

Member ID	111111111-111111111
Name	Last Name, First Name
Request Type	dme pur
Event Classification	Outpatient DME Purchase and Med Supplies
Case Type	Generic

CPM Machine – Knee	E0935	P54
CPM Machine – Other	E0936	P65
DME Purchase and Med Supplies Generic (Outpatient)*	*generic request type (enter codes manually)	P108
DME Rental and Med Supplies Generic (Outpatient)*	*generic request type (enter codes manually)	P107
Insulin Pump Purchase and Pump Supplies	E0784, A4222, A4231-A4232	P15P

Q: How do I add the codes I want approved to my request?

A: From the service line section, follow these steps:

Authorization Request

Service 1
Home/
Durable Medical
Equipment Purchase

1. **Select a service line from the left navigation blue section.** The request type selected determines the number and type of service lines shown. ►
2. **Click on Edit in the Procedure Information section.**
Tip: The Add Procedure function will remain disabled. Use the Edit function only.

Procedure Information

Type	Procedure Low	Procedure High	Primary
☐ Edit CPT	59400 - Vaginal Delivery	59622 - Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery; including postpartum care	✓

3. **Enter the code/code ranges.**
Use the magnifying glass if you need to perform a search.

Edit Procedure

Procedure Low

Procedure High

Quantity Visits

Q: What if I want to add codes to a non-generic request type?

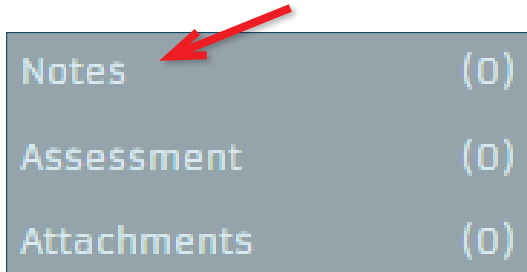
A: This function is not allowed. Remember, non-generic request types are pre-populated templates specifically designed by HNFS according to TRICARE policy.

Section 4: Notes, Assessments and Attachments

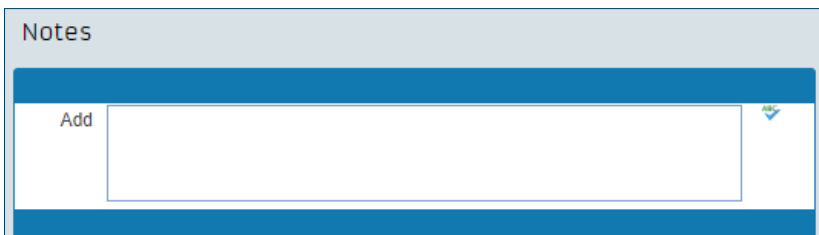
Notes

Use the **Notes** feature to provide HNFS with additional information about your request, such as clinical information in support of urgent requests.

1. Click on **Notes**.



2. Type in the **Add** box. What you type in will automatically save.



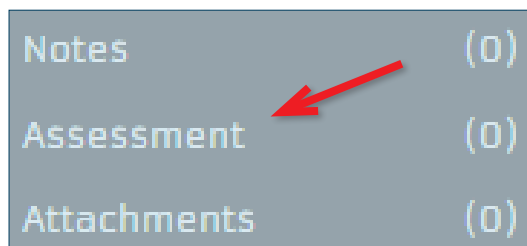
3. Only click **Submit** button in the upper right corner if you are done with the **Notes, Assessments, Attachments** section. Once you hit the Submit button, your submission will complete. ►



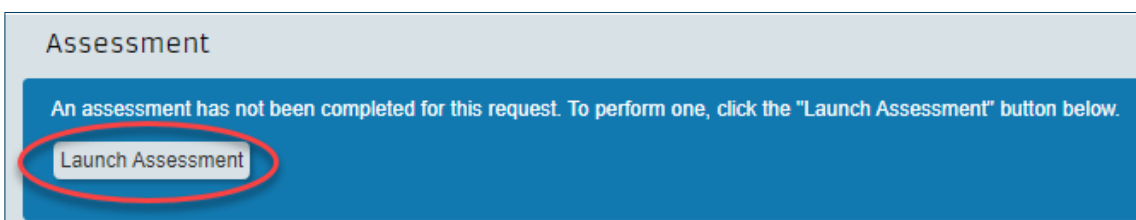
Assessments

Use the **Assessment** feature to suggest patient and provider demographic updates and to supply rationale for requesting a non-network servicing provider.

1. Click on **Assessment**.



2. Click on **Launch Assessment**.



Section 4: Notes, Assessments and Attachments (Continued)

3. Complete the appropriate fields.

*Tip: The **Assessment** feature also allows you to type in clinical documentation notes, but you do not need to repeat information put in the **Notes** section.*

☐ Submit Member Contact Information Change MET

☐ Do you have a member address or phone change to apply to this request?

(None) ▼

4. Click the Complete button.

Complete Cancel

5. Only click Submit button in the upper right corner if you are done with the Notes, Assessments, Attachments section. Once you hit the Submit button, your submission will complete. ▶

Submit

Attachments

Use the **Attachments** feature to add supporting clinical documentation, such as Letters of Attestation.

1. Click on **Attachments**.

Notes (0)

Assessment (0)

Attachments (0) ←

2. Click on **Add File**.

Add File

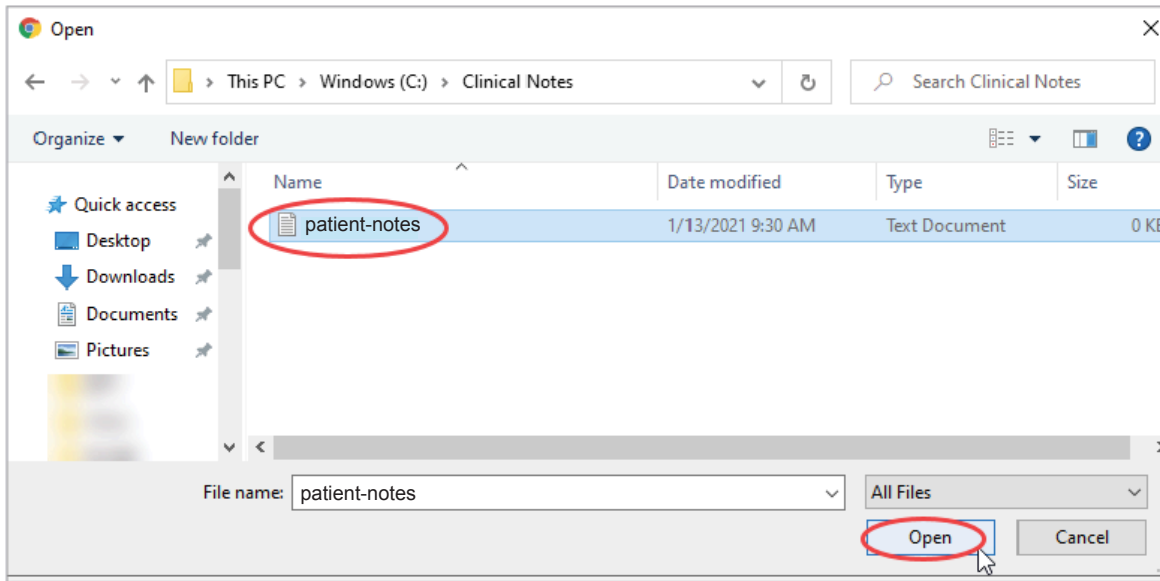
Status

File Name	CDA Title	Date/Time Attached	File Size	Status
There are no records to display.				

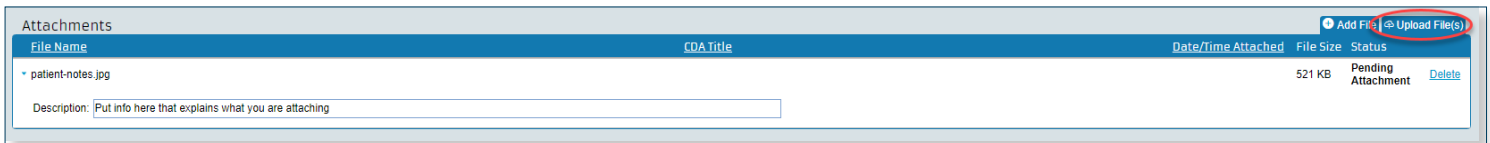
Add File

Section 4: Notes, Assessments and Attachments (Continued)

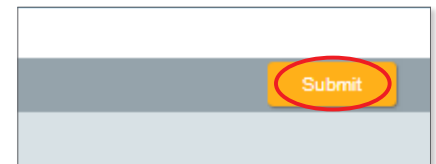
3. Navigate to the file you wish to upload.



4. Upload the file to CareAffiliate.



5. Only click Submit button in the upper right corner if you are done with the Notes, Assessments, Attachments section. Once you hit the Submit button, your submission will complete. ►



Section 5: Checking Status

1. Navigate to the **Authorizations** screen and either search by Member ID or reference number.

CareAffiliate®

HomeAuthorizationsProgram EnrollmentCare PlanHelp

Welcome Joshua Marshall | Log Out

Authorizations

Search Criteria

Member ID

Click Look Up icon →

Q

Name

Requesting Provider ID

Click Look Up icon →

Q

Name

Requesting Group ID

Click Look Up icon →

Q

Name

Location

Include location as criteria

Servicing Provider ID

Click Look Up icon →

Q

Name

Servicing Group ID

Click Look Up icon →

Q

Name

Location

Include location as criteria

Servicing Facility ID

Click Look Up icon →

Q

Name

Location

Include location as criteria

Reference #

000000

UIN

Diagnosis

Code

Description

Q

Procedure

Q

Place of Service

(Any)

Service

Service Dates From

To

Submission Dates From

To

Status

(Any)

Reference #

Authorization #

Member ID

Member Name

Member DOB

Status

Diagnosis

There are no records to display.

2. Select the authorization returned by the search results.

CareAffiliate®

HomeAuthorizationsProgram EnrollmentCare PlanHelp

Welcome Joshua Marshall | Log Out

Authorizations

Search Criteria

Member ID

Click Look Up icon →

Q

Name

Requesting Provider ID

Click Look Up icon →

Q

Name

Requesting Group ID

Click Look Up icon →

Q

Name

Location

Include location as criteria

Servicing Provider ID

Click Look Up icon →

Q

Name

Servicing Group ID

Click Look Up icon →

Q

Name

Location

Include location as criteria

Servicing Facility ID

Click Look Up icon →

Q

Name

Location

Include location as criteria

Reference #

012345

UIN

Diagnosis

Code

Description

Q

Procedure

Q

Place of Service

(Any)

Service

Service Dates From

To

Submission Dates From

To

Status

(Any)

Reference #

Authorization #

Member ID

Member Name

Member DOB

Status

Diagnosis

012345

1111111111-1111111111

Last Name, First Name

01/01/01

Pended

G47.33 Obstructive sleep area (adlt)(ped)

Section 5: Checking Status (Continued)

3. **View the authorization status.** You can monitor the status by logging in to CareAffiliate and/or print a copy of this page for your records. HNFS will notify you if additional information is needed.

CareAffiliate®

LAST NAME, FIRST NAME • MALE • AGE • Reference #123456 • (Pended)

Return To Search

Authorization Request

Service 1 - (Pended)
Outpatient/
Office Visit Professional

Service 2 - (Pended)
Outpatient/
Office Visit Professional

Service 3 - (Pended)
Outpatient/
Office Visit Professional

Notes (0)

Assessment (0)

Attachments (1)

General Information

Member ID

111111111-111111111

Name

Last Name, First Name

Request Type

Evaluate and Treat Specialty Referral

Event Classification

Elective/Routine

Case Type

Specialty referral

Requester

Contact Name

Last Name, First Name

Contact Phone

(123) 456-7890

Requesting Provider/Facility

12345-67890-0000 - DOE, JANE

Diagnoses

Diagnosis

ICD10-G47.33 Obstructive sleep apnea (adult) (pedia

Online Referral/Authorization Submissions Request Type Guide



What is a request type?

Request types are templates created for use with Health Net Federal Services, LLC's (HNFS) online referral and authorization submission tools, available at www.tricare-west.com > *Provider*. Each request type has been developed by HNFS in accordance with the TRICARE manuals.

When a request type is selected, the associated codes/code ranges, number of visits, and duration of the authorization will pre-populate on the request.

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Outpatient Specialty Referral Request Types

Description	Included CPT® Code(s)	Request Type	Approval Duration
Evaluate and Treat Specialty Referral	99202–99205, 99211–99215, 99242–99245	P1	180 days for ADSMs 365 days for non-ADSMs
Evaluate Only Specialty Referral	99202–99205, 99211–99215, 99242–99245	P3	180 days
Oncology – Evaluate and Treat Spec Ref	99202–99205, 99211–99215, 99242–99245	P6	365 days
Pre/Post Transplant	99211–99215, 99242–99245	P58	360 days for codes 99211–99215 90 days for codes 99242–99245
Routine Eye Examination	92002–92015	P63	90 days
Second Opinion	99202–99205, 99211–99215, 99242–99245	P5	90 days
Specialty Referral Extension	99211–99215	P4	180 days, dependent on initial episode of care date

ADSMs = active duty service members

Request types, descriptions and corresponding codes are subject to change.

Outpatient Authorization Request Types

Physical Health

The Approval Duration column shows HNFS' standard authorization time frames. However, if the PCM's specialty referral is still valid (see p.2 for referral durations), servicing providers should request a date extension using the online **Authorization Change Request Form** rather than asking the PCM for a new referral. (Exception: For physical, speech and occupational therapy, and applied behavior analysis [ABA] and Extended Care Health Option [ECHO] services, please submit a new authorization request to HNFS.)

Description	Included CPT®, NDC, HCPCS Codes	Request Type	Approval Duration
ACD ABA Initial Assessment Authorization	97151	P174	45 days
ACD Outcome Measure Authorization	97151, 97151, 97151	P175	365 days
ACD ABA Treatment Authorization	97151, 97153, 97155, 97156, 97157, 97158, 99366, 99368	P177	180 days
ACD ABA Discharge Report Submission	99199	P178	1 day
Acupuncture	97810	P163	90 days
Adjunctive Dental*	*generic request type (enter codes manually)	P127	180 days
Air Ambulance Services	A0430–A0431	P116	14 days
Allergy Services	95004, 95017–95117	P9	180 days
Ambulance Services	A0999	P10	14 days
Audiology	92550, 92552–92557, 92563–92584, 92588	P11	90 days
Breastfeeding Counseling	99401–99404, 99411–99412	P159	365 days
Cardiac Rehabilitation	93797–93798	P12	180 days
Cardiovascular Testing	78472–78473, 78481–78483, 93000–93010, 93015–93018, 93224–93229, 93303–93308, 93320–93325, 93350–93352, 99202–99205, 99211–99215, 99242–99245	P121	365 days
Chiropractic Care	98940–98943	P14	90 days
Colonoscopy	45300–45392, 44388–44388, 99202–99205, 99211–99215, 99242–99245	P43	365 days
Custodial Care Home	99600	P165	30 days
Dental Anesthesia	41899, 00170	P101	180 days
Dental/Adjunctive Dental Svc Data Entry	D9310, 992202–99205, 99242–99245	P22	180 days
Diabetic Education	G0108–G0109	P23	180 days
Diabetic Eye Exam	92082, 92250, 99203–99204	P114	90 days
Dialysis	90935	P60	90 days
Doula/Childbirth Support Services	59899, 99509, T1032, T1033	P180	270 days
Emergency Room Visit	99281–99285	P44	5 days after and 15 days prior to the date of service
Global OB	59400–59622	P76	11 months
Global OB ICD-10	59400–59622	P126	11 months
Hippotherapy	S8940	P124	180 days
Home Health Infusion Therapy*	99601–99602 *generic request type (can also enter codes manually)	P28	90 days for codes 99601–99602 180 days for all others
Home Health Basic Benefit Under PPS	0023	P26	60 days
Hospice	0651–0657, 0551, 0561, 0571	P46A	90 days
Hourly Skilled Nursing	99347	P48	90 days
Injection, Epidural (Cervical or Thoracic)	62320–62321, 77003	P30	90 days
Injection, Epidural (Lumbar or Sacral)	62322–62323, 77003	P31	90 days
Injection, Facet Joint (Cervical or Thoracic)	64490–64492	P32	90 days
Injection, Facet Joint (Lumbar or Sacral)	64493–64495	P33	90 days
Injection, HPV	90649	P29	180 days
Integrated Disability Evaluation	99456	P111	180 days

Mammogram/Breast Biopsy	10021–10021, 19000–19001, 19081–19086, 19100–19101, 76641–76642, 76942–76942, 77002–77002, 77011–77012, 77021–77021, 77065–77066, 99202–99205, 99211–99215 99242–99245, G0279	P181	365 days
Maternity Ultrasounds	76801–76817	P34	90 days
MRI Brain	70544–70544, 70551–70554	P182	365 days
MRI Chest	71550–71555	P183	365 days
MRI Lower Extremity	27093–27096, 27648–27648, 73525–73525 73580–73580, 73615–73615, 73718–73723 77002–77002, 77012–77012	P184	365 days
MRI Orbit Face	70540–70543	P186	365 days
MRI Pelvis	72195–72197	P187	365 days
MRI Spine	72141–72148, 72156–72158	P188	365 days
MRI Upper Extremity	23350–23350, 24220–24220, 25246–25246 73040–73040, 73085–73085, 73115–73115 73218–73223, 77002–77002, 77012–77012	P185	365 days
Non-USFDA LDTs Demo*	*generic request type (enter codes manually)	P162	60 days
Nutritional Counseling	97802–97804, G0270–G0271	P24	90 days
Observation Stay	G0378–G0379	P35	10 days
Occupational Therapy – Acute Injuries	97165, 97167–97168, 97010, 97016–97024, 97028, 97033–97036, 97110–97124, 97140–97150, 95851–95852, 97530, 97535	P36A	120 days
Occupational Therapy – Post Op Care	97165, 97167–97168, 97010, 97016–97024, 97028, 97033–97036, 97110–97124, 97140–97150, 95851–95852, 97530, 97535	P36B	150 days
Occupational Therapy – Long Term Conditions	97165, 97167–97168, 97010, 97016–97024, 97028, 97033–97036, 97110–97124, 97140–97150, 95851–95852, 97530, 7535	P36C	180 days
Opioid Replacement Therapy (ORT)	0912–0913	P152	180 days
Osteopathic Manipulation	98925–98929	P37	90 days
Outpatient Infusion Therapy or Medication Administration*	*generic request type (enter codes manually)	P115	90 days
Outpatient PH Medical Procedure*	*generic request type (enter codes manually)	P106	180 days
Outpatient PH Surgical Procedure*	*generic request type (enter codes manually)	P105	180 days
Physical and Occupational Therapy – Acute Injuries	97165–97168, 97010, 97016–97024, 97028, 97033–97036, 97110–97124, 97140–97150, 97161–97164, 97010, 97016–97024, 97028, 97033–97036, 97110–97124, 97140–97150, 95851–95852, 97530, 97535	P125A	120 days
Physical and Occupational Therapy – Post-Op Care	97165–97168, 97010, 97016–97024, 97028, 97033–97036, 97110–97124, 97140–97150, 97161–97164, 97010, 97016–97024, 97028, 97033–97036, 97110–97124, 97140–97150, 95851–95852, 97530, 97535	P125B	150 days
Physical and Occupational Therapy – Long-Term Conditions	97165–97168, 97010, 97016–97024, 97028, 97033–97036, 97110–97124, 97140–97150, 97161–97164, 97010, 97016–97024, 97028, 97033–97036, 97110–97124, 97140–97150, 95851–95852, 97530, 97535	P125C	180 days
Physical Therapy – Acute Injuries	97161–97164, 97010, 97016–97024, 97028, 97033–97036, 97110–97124, 97140–97150, 95851–95852, 97530, 97535	P38A	120 days
Physical Therapy – Post-Op Care	97161–97164, 97010, 97016–97024, 97028, 97033–97036, 97110–97124, 97140–97150, 95851–95852, 97530, 97535	P38B	150 days
Physical Therapy – Long-Term Conditions	97161–97164, 97010, 97016–97024, 97028, 97033–97036, 97110–97124, 97140–97150, 95851–95852, 97530, 97535	P38C	180 days
Pulmonary Rehabilitation	G0237–G0238	P13	90 days
Pulmonary Rehabilitation Pre/Post Transplant	97161–97163, 97110	P59	30 days for codes 97161–97163 90 days for code 97110

Respite Care for Extended Care Health Option	99600	P47	365 days
Sleep Study	95810–95811	P40	90 days
Sleep Study (Under 6 Years Old)	95782–95783	P123	90 days
Smoking Cessation	96156, 96158–96159, 96164–96165	P62	120 days
Speech Therapy – Acute Injuries	92521–92524, 92507	P39A	120 days
Speech Therapy – Post-Op Care	92521–92524, 92507	P39B	150 days
Speech Therapy – Long-Term Conditions	92521–92524, 92507, 92610	P39C	180 days
Synagis	90378	P67	150 days
Terminal Leave Blanket Authorization	99202–99215, 90791–90792, 99202–99205	P128	This request type is to be used by military hospitals or clinics only
Trigger Point Injections	20552–20553	P41	90 days
Ultrasound Abdominal	76700 –76705, 76770–76775	P189	365 days
Ultrasound Extremity	76881–76882	P190	365 days
Ultrasound Female Pelvic	76830 –76830, 76856–76857	P191	365 days
Ultrasound Infant Hips	76885–76886	P192	365 days
Urgent Care	99202–99205	P45	5 days after and 15 days prior to the date of service
Vestibular Testing	92537–92537, 92540–92544, 92546–92547 99213–99213	P193	365 days
Videofluoroscopic Swallowing Study	74230–74230, 92610–92610	P194	365 days

*= generic request type

Outpatient Authorization Request Types (continued)

Behavioral Health

The Approval Duration column shows HNFS' standard authorization time frames. However, if the PCM's specialty referral is still valid (see p. 2 for referral durations), servicing providers should request a date extension using the online **Authorization Change Request Form** rather than asking the PCM for a new referral.

Description	Included CPT®, NDC, HCPCS Codes	Request Type	Approval Duration
Outpatient Therapy (BH)	90791–90792, 90832–90840, 90846–90853, 99211–99215, 90785, 99202–99205	P50	90 days for codes 90791–90792, 99202–99205 180 days for codes 90832–90840, 90846–90853, 99211–99215, 90785
Electroconvulsive Therapy (BH)	90791–90792, 90870	P64	90 days for codes 90791–90792 180 days for code 90870
IOP Psych (BH)	S9480	P156	90 days
IOP Substance Abuse (BH)	H0015	P157	90 days
Medication Assistant Treatment (BH)*	*generic request type (enter codes manually)	P167	180 days
Medication Management (BH)	99202–99215	P51	180 days
Observation Stay (BH)	G0379	P75	10 days
PHP Psych Full Day (BH)	0913	P71	90 days
PHP Psych Half Day (BH)	0912	P73	90 days
PHP Substance Abuse Full Day (BH)	0913	P72	90 days
PHP Substance Abuse Half Day (BH)	0912	P74	90 days
Psychological/Neuropsychological Testing (BH)	90791–90792, 96130–96146	P171	90 days for codes 90791–90792 180 days for codes 96130–96146
Sparvato® Esketamine (BH)	G2082–G2083	P173	90 days
Transcranial Magnetic Stimulation (BH)	90791–90792, 90867–90869	P166	90 days for codes 90791–90792 365 days for codes 90867–90869

BH = behavioral health, *= generic request type

Durable Medical Equipment Request Types

The Approval Duration column shows HNFS' standard authorization time frames. However, if the PCM referral is still valid (see p. 2 for referral durations), servicing providers may request a date extension using the online **Authorization Change Request Form** rather than going back to the PCM for a new referral.

Description	Included CPT®, NDC, HCPCS Codes	Request Type	Approval Duration
ASV (Adaptive Servo-Ventilation Machine) Purchase and Supplies	E0471, E0562, A7027–A7039, A7046, A4604	P168P	455 days
ASV Rental and Supplies	E0471, E0562, A7027–A7039, A7046, A4604	P168R	455 days
BiPap Purchase and Supplies	E0561–E0562, E0470–E0472, A7030–A7039, A7044–A7046, A4604–A4604	P17P	455 days
BiPap Rental and Supplies	E0561–E0562, E0470 –E0472, A7030–A7039, A7044–A7046, A4604–A4604	P17R	455 days
BiPAP Supplies Only	A4604–A4604, A7027–A7039, A7044–A0746, E0470–E0472, E0561–E0562	P17S	455 days
Breast Pump and Supplies – Heavy Duty Hospital Grade	E0604, A4281–A4286, A9999, A9900	P160	90 days for codes E0604 455 days for codes A4281–A4286, A9999, A9900
Breastfeeding Pump and Supplies	E0602–E0603, A4281–A4286, A9999, A9900	P158	455 days
Commode (3 in 1)	E0163	P57	455 days
CPAP Standard Purchase and Supplies	E0601–E0601, E0561–E0562, A7027–A7039, A7044–A7046, A4604–A4604	P16P	455 days
CPAP Standard Rental and Supplies	E0601–E0601, E0561–E0562, A7027–A7039, A7044–A7046, A4604–A4604	P16R	455 days
CPAP Portable Purchase and Supplies	E0601, E0562, E1399, A7027–A7039, A7046, A4604	P172P	455 days
CPAP Portable Rental and Supplies	E0601, E0562, E1399, A7027–A7039, A7046, A4604	P172R	455 days
CPAP Supplies Only	A7027–A7039, A7044–A7046, A4604–A4604, E0561–E0562	P155	455 days
CPM Machine – Knee	E0935	P54	21 days
CPM Machine – Other	E0936	P65	21 days
DME Purchase and Med Supplies Generic (Outpatient)*	*generic request type (enter codes manually)	P108	455 days
DME Rental and Med Supplies Generic (Outpatient)*	*generic request type (enter codes manually)	P107	455 days
Insulin Pump Purchase and Pump Supplies	E0784, A4222, A4231–A4232	P15P	455 days
Insulin Pump Rental and Pump Supplies	E0784, A4222, A4231–A4232	P15R	455 days
LVAD	L9900	P61	455 days
Nebulizer	A7003–A7003, A7005–A7005, A7013–A7013, A7015–A7015, E0570–E0570	P195	455 days
Personal Incontinence Supplies	A4520, T4521–T4536, T4539, T4543	P161	365 days
Prosthetics and Orthotics Generic (Outpatient)*	*generic request type (enter codes manually)	P109	180 days
Rolling Walker	E0143	P56	455 days
Synthetic Sheepskin Pad	E0188	P55	455 days
TENS Unit – Purchase	E0720, E0730, A4595, E0731	P113	455 days
TENS Unit – Rental	E0720, E0730, A4595, E0731	P112	455 days
Wheelchair Rental – Basic	K0001, E0990	P18	455 days
Wound Vacuum	E2402, A6550, A7000, A4221, A4222	P21	180 days

*= generic request type

Inpatient Authorization Request Types

For use with CareAffiliate® only. The Web Authorization/Referral Form (WARF) does not support inpatient requests.

Description	Included CPT®, NDC, HCPCS Codes	Request Type	Approval Duration
Bariatric Surgery Laparoscopic Roux-en-Y (Inpatient PH)	43644	P97	30 days
Bariatric Surgery Laproscopic Banding (Inpatient PH)	43770–43774	P98	30 days
Bariatric Surgery Open Roux-en-Y (Inpatient PH)	43846	P100	30 days
Bariatric Surgery Vertical Banding (Inpatient PH)	43842	P99	30 days
BH Admit (Inpatient)	99221	P81	5 days
Chemical Dependency (BH CD) – Detoxification	99221	P83	7 days
Chemical Dependency (BH CD) – Rehabilitation	99221	P84	5 days
C-Section Delivery (Inpatient)	59514	P80	180 days
Custodial Care (Inpatient)	99324	P164	30 days
Double Lung Transplant (Inpatient PH)	32852–32584	P89	365 days
Heart Lung Transplant (Inpatient PH)	33935	P90	365 days
Heart Transplant (Inpatient PH)	33945	P94	365 days
Intestinal Transplant (Inpatient PH)	44135–44136	P93	365 days
Islet Cell Transplant (Inpatient PH)	48160	P92	365 days
Kidney Transplant (Inpatient PH)	50360, 50365, 50380	P86	355 for code 50360 365 for code 50365, 50380
Liver Transplant (Inpatient PH)	47135–47136	P87	365 days
Long Term Acute Care (Inpatient PH)	99221	P104	30 days
Medical Admit (Inpatient PH)	99221	P77	5 days
Pancreas Transplant (Inpatient PH)	48554	P91	365 days
Rehabilitation – Acute (Inpatient PH)	99221	P103	30 days
Residential Treatment Center (BH Inpatient)	99221	P82	5 days
Single Lung Transplant (Inpatient PH)	32851	P88	365 days
Skilled Care (Inpatient PH)	0022	P102	30 days
Stem Cell Transplant Allogeneic (Inpatient PH)	38240	P95	365 days
Stem Cell Transplant Autologous (Inpatient PH)	38241	P96	365 days
Surgical Admit (Inpatient PH)*	*generic request type (enter codes manually)	P78	30 days
Vaginal Delivery (Inpatient)	59409	P79	180 days

BH = behavioral health, PH = physical health, *= generic request type